



Mental Health Services  
Of Catawba County  
Draft Local Business Plan

April 1, 2003

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Section IX. Information Systems  
& Data Management

Contact Person:

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Hickory, NC 28602  
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## Local Business Plan: Strategic Plan Matrix

<b>Area Program(s)/County Program</b>	Mental Health Services of Catawba County
<b>Contact</b>	John M. Hardy, Area Director, (828)695-5900, fax (828)695-5949, <a href="mailto:johnh@catawbacountync.gov">johnh@catawbacountync.gov</a>
<b>Submission Date</b>	04/01/03

**Item: IX. Information Systems and Data Management 1**

**Goal: The local business plan is in compliance with IPRS (Integrated Payment and Reporting System) and MMIS (Medicaid Management Information System) requirements.**

**Effective Date: 04/03**

Steps Taken	Steps Planned	Barriers
<p>A signed Trading Partner Agreement with EDS and Division MOA are completed and on file.</p> <p>HIPPA EDI Transaction sets:  ANSIX12N 834 ( Client Eligibility Enrollment)  ANSIX12N 835 (Remittance Advice)  ANSIX12N 837 (Professional Claim Format)  These EDI sets are in the test stages for implementing the IPRS system. All have been certified for their Format and certification for their Content is in progress.</p>	<p>Content certification and implementing of IPRS</p>	<p>Time elements involved in process</p>

<p>Programs have been developed to allow the establishment of the client target populations and the cross-referencing of clients to the MMIS system.</p> <p>Assignment of target populations for active clients. IPRS scheduled for Phase III implementation.</p> <p>Security for use of the <a href="#">Report@Web</a> has been applied for and received for staff in Reimbursement, Financial, and Medical Records areas. Training at the state level has been completed for staff involved with the <a href="#">Report@Web</a>.</p> <p>A program (Secure FX) for generating a Secure Socket Layer (SSL) with 128-bit encryption that meets RC4 or Triple Data Encryption standard has been purchased and will be installed on required PC's.</p> <p>We have the ability to adhere to the MMIS and IPRS requirements at this time.</p>	<p>Implement with the Transaction Content Certification.</p>	
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<p><b>Reviewers Comments:</b></p>
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## Local Business Plan: Strategic Plan Matrix

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<b>Contact</b>	John M. Hardy, Area Director, (828)695-5900, fax (828)695-5949, <a href="mailto:johnh@catawbacountync.gov">johnh@catawbacountync.gov</a>
<b>Submission Date</b>	04/01/03

### Item: IX. Information Systems and Data Management 2

**Goal: The local business plan adheres to the state technology standards.**

**Effective Date: 04/03**

Steps Taken	Steps Planned	Barriers
<p>Reviewed and confirmed compliance with the statewide technical architecture as published by IRMC.</p> <p>Reviewed existing policies and procedures relating to security/ access controls to data and systems, privacy and confidentiality.</p> <p>Reviewed existing policies outlining the necessary steps in maintaining and assuring dissemination of policy to Quality Management Team, program managers, and in turn to supervisors and staff.</p>		

<p>There is a network map available from Catawba County Information Technology Center (ITC) department that provides topology information and a complete inventory list of all hardware and software.</p> <p>A complete listing of all users and their access levels to data and systems is maintained concurrently with Mental Health Services of Catawba County (MHSCC) and the Catawba County ITC.</p> <p>Symantec AntiVirus Corporate Edition is used for monitoring and protection across the network.</p> <p>Cyberguard Firewalls and ITS routers are used to protect and monitor the connection between MHSCC and the Division.</p> <p>“Wiring Topologies and Data Link Standards” used are available from Catawba County ITC department. There are policies in place relating to “Disaster Recovery and Security”, “Windows Operating Systems”, and “Administration Support and Training” as published by Information Technology Services (ITS)</p>		
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<p><b>Reviewers Comments:</b></p>
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## Local Business Plan: Strategic Plan Matrix

<b>Area Program(s)/County Program</b>	Mental Health Services of Catawba County
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<b>Submission Date</b>	04/01/03

### Item: IX. Information Systems and Data Management 3

**Goal:** A policy is evident that adopts all security procedures established by the Division of MH/DD/SAS both for the protection and the safeguarding of electronic data, financial assets and other material resources.

**Effective Date:** 04/03

Steps Taken	Steps Planned	Barriers
<p>Reviewed and/or updated existing policies to show evidence of state security procedure compliance as those requirements are currently defined. Policies were drafted to reflect LME role, addressing areas such as workstation use (Attachment A), portable computers (Attachment B), MIS backup (Attachment C) and e-mail (Attachment D).</p> <p>A comprehensive policy has been drafted to address HIPAA security. A HIPAA Security Officer is</p>	<p>New Security policy to be reviewed by HIPAA Task Force, Quality Management Team and Area Board.</p>	

in place. Additionally, an extension for HIPAA implementation was granted. (Attachment E) Policy will remain in draft form until regulations and expectations have been clarified and finalized. (Attachment F)		
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<p><b>Reviewers Comments:</b></p>
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- Attachment A – Draft Workstation Use Policy**
- Attachment B - Draft Portable Computer Policy**
- Attachment C – Draft MIS Backup Policy**
- Attachment D – Draft E-Mail Policy**
- Attachment E – HIPAA Extension**
- Attachment F – Draft Security Policy**

DRAFT

Mental Health Services of Catawba County

**POLICIES AND PROCEDURES**

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ACTIVITY: LOCAL MANAGING ENTITY (LME)

Number:

Effective Date:

SUBJECT: INFORMATION SYSTEMS - WORKSTATION Amended Effective:  
USE

Board Approved:

QMT Approved: 02/14/03

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POLICY:

The Mental Health Services of Catawba County (MHSCC) Area Board adopts this Workstation Use Policy to comply with its duty to protect the confidentiality and integrity of confidential medical information as required by law, professional ethics, and accreditation requirements.

PROCEDURE:

1. MHSCC personnel should assume the following:

Every computer workstation in the facility is vulnerable to environmental threats, such as fire, water damage, power surges, etc.

Any computer workstation in the facility can access confidential consumer information if the user has the proper authorization.

All computer workstation screens are visible to individuals who do not have access to confidential information that may appear on a screen.

2. MHSCC personnel will adhere to the following:

All computer workstations that are plugged into an electrical power outlet shall use a surge protector

Staff logging onto the computer workstation will ensure that no one observes the entry of his/her password

Staff will not log onto a computer workstation using another's password nor permit another to log on with his/her password. The exception to this rule would be for ITC or IS staff to use a password during maintenance or assistance from the help desk. Afterwards the user will need to change their password.

Staff will not write down his/her password and leave it in a unsecured location.

Each staff using the facility's computer workstation is responsible for the content of any data he/she enters into the computer workstation or transmits through or outside the facility's system.

Mental Health Services of Catawba County

**POLICIES AND PROCEDURES**

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ACTIVITY: LME                      SUBJECT: INFORMATION SYSTEMS – WORKSTATION USE

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EFFECTIVE:                      AMENDED:                      NUMBER

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Staff should not attempt to access any confidential information outside his/her approved access levels.

No staff may disclose confidential information unless properly authorized.

Staff should leave no unsecured printer unattended while printing confidential information.

Any facility computer workstation may not be used for personal solicitation of outside business ventures, organizational campaigns, and political or religious purposes; nor may it be used to enter, transmit, or maintain communication of a discriminatory or harassing nature, or materials that are obscene or X-rated. No staff shall enter, transmit or maintain messages with derogatory or inflammatory remarks about an individual's race, age, disability, religion, national origin, physical attributes, sexual preference or health condition. No staff shall enter, transmit or maintain any abusive, profane or offensive language (See Catawba County Codes 270.104, 270.171, 270.181 and Catawba County Electronic Communication Policy)

Computer workstations in all clinical areas will be programmed to generate a screen saver when left unused for 90 seconds or more. All computer workstations not in a clinical area will be programmed to generate a screen saver based on the use of that workstation.

Staff must log off the CMHC software package when they will be away from their computer workstation for more than 15 minutes.

No staff may download data from the facility's system without prior authorization from the MHSCC Security Officer, Director of MHSCC or a Designee of MHSCC.

No staff shall load or download software on the computer workstation without prior authorization of the MHSCC Security Officer, Director of MHSCC or a Designee of MHSCC.

**Enforcement**

All supervisors are responsible for enforcing this policy. Employees who violate this policy are subject to discipline up to and including termination from employment in accordance with the Facility Sanction Policy.

HISTORY NOTE:                      Approved by QMT on 02/14/03. Approved by the Mental Health Board on and effective.

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Mental Health Services of Catawba County

**POLICIES AND PROCEDURES**

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ACTIVITY: LOCAL MANAGING ENTITY (LME)

SUBJECT: INFORMATION SYSTEMS -  
PORTABLE COMPUTERS

Number:

Effective Date:

Amended Effective:

Board Approved:

QMT Approved: 02/14/03

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POLICY:

The Mental Health Services of Catawba County (MHSCC) Area Board adopts this Portable Computer Policy to comply with its duty to protect the confidentiality and integrity of confidential medical information as required by law, professional ethics, and accreditation requirements.

PROCEDURE:

All personnel of MHSCC who use a laptop, notebook, or other portable computer device must be familiar with this policy. Demonstrating competence in the requirements of this policy is an important part of every MHSCC employee's responsibilities.

No person may use a MHSCC portable computer without the authorization of the Security Officer, Director of MHSCC or a Designee of MHSCC. No user may, for any purpose, download, maintain, or transmit confidential patient or other information on a portable computer without the authorization of the Security Officer, Director of MHSCC or a Designee of MHSCC.

MHSCC has issued the computer equipment shown on the Portable Equipment Log for specifically-authorized uses. The hardware, software, all related components, and data are the property of MHSCC and must be safeguarded and returned upon request or upon the termination of employment.

The user agrees to use the equipment solely for MHSCC business purposes. The user further understands:

Dial-in functions are provided for the sole purpose of allowing the user to perform MHSCC computer-related functions.

User is not permitted to use this equipment/software to access any unauthorized services, Internet Service Provider, Internet Access, or to use the dial-up capabilities in any other manner than as authorized. The user understands that the hardware has been disabled from performing any functions other than those intended for MHSCC business use and that the user may not attempt to enable other functions.

Computers, associated equipment, and software are for business use only, not for the personal use of the user or any other person or entity.

Users will not download any software onto the computer except as authorized by the MHSCC Security Officer, Director of MHSCC or a Designee of MHSCC.

Mental Health Services of Catawba County

**POLICIES AND PROCEDURES**

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ACTIVITY:LME

SUBJECT: PORTABLE COMPUTER

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EFFECTIVE:

AMENDED:

NUMBER

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Users will not insert any floppy disks, CDs, or other media into the computer without the authorization of the Security Officer, Director of MHSCC or a Designee of MHSCC.

Users must use only batteries and power cables provided by MHSCC and may not, for example, use their car adaptor power sources.

Users will not connect any additional peripheral devices (keyboards, printers, modems, etc.) without the express authorization of MHSCC management or its agent.

Users are responsible for securing the unit, all associated equipment, and all data within their homes, cars, and other locations as instructed in the training provided.

Users may not leave portable computer units unattended unless they are in a secured location.

Users may not leave portable computer units in cars or car trunks for an extended period in extreme weather (heat or cold) or leave them exposed to direct sunlight.

Users must place portable computers and associated equipment in their proper carrying cases when transporting them.

Users must not alter the serial numbers and asset numbers of the equipment in any way.

Users will not permit anyone else to use the computer for any purpose, including but not limited to, the user family and/or associates, patients, patient families, or unauthorized officers, employees, and agents of MHSCC.

Users must not share their passwords with any other person and must safeguard their passwords and may not write them down so that an unauthorized person may obtain it. Should MIS or an Agent of MIS of MHSCC request a user's password to perform hardware/software maintenance on the portable system, it will be the user's responsibility to change his/her password once maintenance is completed.

Users must immediately report any breach of password security to the Security Officer or the Director of MHSCC.

Mental Health Services of Catawba County

**POLICIES AND PROCEDURES**

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ACTIVITY:LME

SUBJECT: PORTABLE COMPUTER

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EFFECTIVE:

AMENDED:

NUMBER

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Users must maintain patient confidentiality when using the computers, as specified in MHSCC Workstation Policy. The screen must be protected from viewing by unauthorized personnel, and users must properly log out and turn off the computer when it is not in use.

Users must immediately report any lost, damaged, malfunctioning, or stolen equipment or any breach of security or confidentiality to the Security Officer, Director of MHSCC or a Designee of MHSCC.

It is understood that once the portable equipment has been returned to MHSCC that all data files and software programs will be removed from this equipment. There will be no inventory maintained of the data files removed; therefore there will be no Recovery Procedure established.

**Enforcement**

All supervisors are responsible for enforcing this policy. Employees who violate this policy are subject to discipline up to and including termination from employment in accordance with the Facility Sanction Policy.

HISTORY NOTE:

Approved by QMT on 02/14/03. Approved by the Mental Health Board on and effective.

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Mental Health Services of Catawba County

**POLICIES AND PROCEDURES**

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ACTIVITY: LOCAL MANAGING ENTITY (LME)

SUBJECT: INFORMATION SYSTEMS – MIS BACKUP

Number:

Effective Date:

Amended Effective:

Board Approved:

QMT Approved: 02/14/03

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POLICY:

The Mental Health Services of Catawba County (MHSCC) Area Board adopts this MIS Backup Policy to comply with its duty to protect the quality, assurance, and continued resource availability needed to support the confidentiality and integrity of confidential medical information as required by law, professional ethics, and accreditation requirements.

PROCEDURE:

Network and CMHC servers will, at the end of each business day, perform an unattended write of all data stored on them to magnetic tape. These tapes, once verification of correctness is complete, will be removed from the site to an offsite location for safekeeping. Once written, a tape will not be recycled for use for a period of no less than one month.

HISTORY NOTE:

Approved by QMT on 02/14/03. Approved by the Mental Health Board on and effective.

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Mental Health Services of Catawba County

**POLICIES AND PROCEDURES**

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ACTIVITY: LOCAL MANAGING ENTITY (LME)

Number:

SUBJECT: INFORMATION SYSTEMS – E-MAIL

Effective Date:

Amended Effective:

Board Approved:

QMT Approved: 02/14/03

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POLICY:

The Mental Health Services of Catawba County (MHSCC) Area Board adopts this e-Mail Policy to allow the use of e-mail to communicate more efficiently between MHSCC staff. E-mail communications are the property of MHSCC and *e-mail users do not have a right to privacy in their use of computer system or it's e-mail component.*

PURPOSE:

To allow the use of e-mail to communicate more efficiently between MHSCC staff.

Use of the e-mail system constitutes consent to this policy.

PROCEDURE:

1. E-mail usage should be limited to communicating for business purposes or to the coordination of client treatment or care.
2. When e-mailing confidential information about a client to other MHSCC staff, use only the client record number and the first name and last initial for identification. All MHSCC staff have access to CMHC and they are able to look up the client ID number to identify the client by name.
3. When e-mailing client information to someone outside of MHSCC, such as Department of Social Services or Public Health, use the client's first name and last initial followed by his/her date of birth or social security number for identification.
4. Any pertinent clinical information shared via e-mail regarding a client should be printed and have the client full name and record number written on it. It will then be forwarded to the medical records area for filing in the client's medical record chart. E-mail correspondence will be filed behind the correspondence tab.
5. Users must not forward confidential client information to any outside agency unless prior approval is obtained from the MHSCC Privacy Officer.
6. MHSCC reserves the right to monitor, audit, delete and read e-mail messages because the e-mail system is a component of business equipment and is owned by this facility.
7. E-mails will contain the least amount of confidential information possible while still providing the e-mail recipient all necessary information.

Mental Health Services of Catawba County

**POLICIES AND PROCEDURES**

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ACTIVITY: LME SUBJECT: INFORMATION SYSTEMS – E-MAIL

EFFECTIVE DATE: AMENDED DATE: NUMBER

E-mailing client information to other agencies must be approved by the MHSCC Privacy Officer.

**Enforcement**

All supervisors are responsible for enforcing this policy. Employees who violate this policy are subject to discipline up to and including termination from employment in accordance with the Facility Sanction Policy.

HISTORY NOTE: Approved by QMT on 02/14/03. Approved by the Mental Health Board on and effective on



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# Electronic Health Care Transactions and Sets Standards Model Compliance Plan

Progress - Step 4 of 5



**Stop! Your compliance plan will not be submitted until you r  
your responses and click "Submit This Plan Electronically" a  
bottom of the page.**

### Section A: Covered Entity and Contact Information

1. Name of Covered Entity: **Catawba County North Carolina**
2. Tax Identification Number: **56-6001814**
3. Medicare Identification Number: **2873553**
4. Type of covered entity:  
**Health Care Provider - Other**
5. Authorized Person: **Jerry E Hess**
6. Title: **Attorney**
7. Street: **100A S. West Boulevard**
8. City/State/ZIP: **Newton, NC 28658**
9. Telephone Number: **(828) 465 - 8206**

### Section B: Reason for Filing for This Extension

10. Please check the box next to the reason(s) that you do not exp  
be compliant with the HIPAA Electronic Health Care Transactions a  
Code Sets standards (45 C.F.R. Parts 160, 162) by October 16, 20  
Multiple boxes may be checked.

**Need more time to complete implementation**

**Section C: Implementation Budget**

This question relates to the general financial impact of the HIPAA Electronic Health Care Transactions and Code Sets standards (45 C.F.R. Parts 160,162) on your organization

11. Select from the drop-down menu the range of your estimated compliance with the HIPAA Electronic Health Care Transaction and Sets standards (45 C.F.R.,Parts 160,162):

**Don't Know**

**Section D: Work Plan/Implementation Strategy/Testing Strategy**

This section encompasses HIPAA Awareness, Operational Assessment Development and Testing, all of which are collectively referred to as the Transactions and Code Sets Implementation Process. For more details on completing each of these subsections, refer to the "Help on this question" links for each individual question.

**Phase One - HIPAA Awareness**

These questions relate to your general understanding of the HIPAA Electronic Health Care Transactions and Code Sets standards (45 C.F.R. Parts 160,162).

12. Please indicate whether you have completed this Awareness phase of the Implementation Process.

**Yes**

13. Projected/Actual Start Date:

14. Projected/Actual Completion Date: **October, 2002**

**Phase Two - Operational Assessment**

These questions relate to HIPAA operational issues and your progress in this area.

15. Please indicate whether you have completed this Operational Assessment phase of the Implementation Process.

**Yes**

16. Reviewed current processes against HIPAA Electronic Health Care Transactions and Code Sets(45 C.F.R Parts 160,162) requirements?

17. Identified internal implementation issues and developed workplan?

18. Decided whether to use the services of a vendor or other contractor?

19. Projected/Actual Start Date:

20. Projected/Actual Completion Date: **October, 2002**

### Phase Three - Development and Testing

These questions relate to HIPAA development and testing issues. ASCA legislation requires that testing begin no later than April 16, 2003. For more details, refer to the "Help on this question" links for each individual question.

21. Please indicate whether you have completed this Development and Testing phase of the implementation process.  
**No**

22. Completed software development/installation?  
**Initiated But Not Completed**

23. Completed staff training?  
**Yes**

24. Projected/Actual Development Start Date: **July, 2002**

25. Projected/Actual Initial Internal Software Testing Start Date: **March, 2003**

26. Projected/Actual Testing Completion Date: **July, 2003**

Submit This Plan Electronically

Cancel This Plan and Start Over

Last Modified on Friday, August 30, 2002





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## Electronic Health Care Transactions and Code Sets Standards Model Compliance Plan

Progress - Step 5 of 5



**Stop! Please read the following information regarding your confirmation number.**

**Your confirmation number is: 1358351**

Thank you! Your Electronic Transactions and Code Sets Compliance Extension Plan has been submitted to CMS.

**This page serves as your only form of confirmation.** You will not receive further confirmations via regular mail or email.

Please print out this page or record your confirmation number for proof of submission.

**Do you need to file for multiple entities that are included under the same implementation plan that you just filed?** If so, please click the button below and you can enter their information for items 1-4 in Section A. The rest of the information on the form will be the same as the plan you just filed and this information will be filled in on the form to speed the filing process.

[File for Multiple Entities on this Plan](#)

[Return to the Compliance Extension Plan Homepage](#)

Last Modified on Friday, August 30, 2002

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Mental Health Services of Catawba County

**POLICIES AND PROCEDURES**

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ACTIVITY: LOCAL MANAGING ENTITY (LME)

SUBJECT: SECURITY

Number:

Effective Date:

Amended Effective:

Board Approved:

QMT Approved:

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**POLICY**

It shall be the policy of Mental Health Services of Catawba County (MHSCC) that all personnel will preserve the integrity and the confidentiality of medical and other sensitive information pertaining to our consumers in accordance with the NC Division's "Confidentiality Rules" (APSM 45-1), Federal Rules 42 C.F.R. Part 2 "Confidentiality of Alcohol and Drug Abuse Patient Records", Federal Rules 34 C.F.R. part 300, subpart E, Sections 300-560 through 300.575 "Confidentiality of Infants and Toddlers Receiving Early Intervention Services" and federal HIPAA regulations. Where there is a conflict of state vs. federal law, the most restrictive will apply. (4.003)

The Medical Records Manager has been delegated the authority and responsibility for providing instructions to all personnel on current state and federal confidentiality regulations. (4.003A)

All officers, employees and agents of MHSCC must adhere to this policy. MHSCC will not tolerate violations of this policy. Violation of this policy is grounds for disciplinary action, up to and including termination of employment and criminal or professional sanctions in accordance with Mental Health Services of Catawba County's personnel rules and regulations. (4.003A)

**Mental Health Services of Catawba County will:**

1. Collect and use individual medical information only for the purposes of providing medical services and for supporting the delivery, payment, integrity and quality of those services. MHSCC and its officers, employees and agents will not use or supply individual medical information for non-health care uses such as direct marketing, employment or credit evaluation purposes.
2. Maintain a medical record on all persons to whom services are provided to serve the client, the provider of client care and the Area Program in accordance with legal, accreditation and regulatory agency requirements.
3. Collect and use individual medical information ONLY:
  - a. To provide proper diagnosis and treatment
  - b. With the individual's knowledge and consent
  - c. To receive reimbursement for services provided
  - d. As a basis for required reporting of health information
  - e.
4. Recognize that medical information collected about consumers must be accurate, timely, complete and available when needed. MHSCC and its officers, employees and agents will:

Mental Health Services of Catawba County

**POLICIES AND PROCEDURES**

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ACTIVITY: LME

SUBJECT: SECURITY

EFFECTIVE DATE:

AMENDED EFFECTIVE:

NUMBER:

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- a. Use their best efforts to ensure the accuracy, timeliness and completeness of data and to ensure that authorized personnel can access it when needed.
  - b. Complete and authenticate medical records in accordance with the law, medical ethics, and accreditation standards. (Procedure I-Authentication of Entries in the Client Record.)
  - c. Maintain medical records for the retention periods required by law and professional standards. (see APSM 10-3 "Records Retention and Disposition Schedule for State and Area Facilities")
  - d. Not alter or destroy an entry in a record, but rather designate it as an error while leaving the original entry intact and create and maintain a new entry showing the correct data. (Procedure II- Alterations to Client Records)
  - e. Implement reasonable measures to protect the integrity and security of all data maintained about consumers. (Procedure III- Security/Accessibility of Client Records)
5. Recognize that patients have a right to privacy. MHSCC and its officers, employees and agents will respect consumers' individual dignity at all times. MHSCC and its officers, employees and agents will respect consumers' privacy to the extent consistent with providing the highest quality behavioral healthcare possible and with the efficient administration of the facility. (Procedure IV-Assurance of Confidentiality)
6. Act as responsible information stewards and treat all individual medical record data and related financial, demographic and lifestyle information as sensitive and confidential. MHSCC and its officers, employees and agents will:
  - a. Treat all individual medical record data as confidential in accordance with professional ethics, accreditation standards and legal requirements.
  - b. Not divulge medical record data unless the consumer (or his or her authorized representative) has properly consented to the release or the release is otherwise authorized by law, such as communicable disease reporting, child abuse reporting and the like. The client will be made aware of the circumstances in which information may be released without authorization at the time of admission to the Area Program. The Medical Records Manager is responsible for information released/disclosed. He/she shall consult with the Clinical Director or other authorities/legal counsel when a question of propriety of the release/disclosure of confidential information occurs. (Procedure V- Release of Information with Consent of Client, Procedure VI- Release of Information without Consent of Client)
  - c. When releasing medical record data, take appropriate steps to prevent unauthorized re-disclosures, such as specifying that the recipient may not further disclose the information without patient consent or as authorized by law. (Procedures V & VI)
  - d. Implement reasonable measures to protect the confidentiality of medical and other information maintained about consumers. (Procedure III)
  - e. Remove consumer identifiers when appropriate, such as in statistical reporting.

Mental Health Services of Catawba County

**POLICIES AND PROCEDURES**

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ACTIVITY: LME

SUBJECT: SECURITY

EFFECTIVE DATE:

AMENDED EFFECTIVE:

NUMBER:

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- f. Not disclose financial or other patient information except as necessary for billing or other authorized purposes as authorized by law and professional standards.
7. Recognize that some medical information is particularly sensitive, such as HIV/AIDS information, mental health and developmental disabilities information, alcohol and drug abuse information and other information about sexually transmitted or communicable diseases, and that disclosure of such information could severely harm consumers, such as by causing loss of employment opportunities and insurance coverage, as well as the pain of social stigma. MHSCC and its officers, employees and agents will treat such information with additional confidentiality protections as required by law, professional ethics and accreditation requirements. (Procedure V)
8. Recognize that, although the medical record is the property of MHSCC, the consumer has a right of access to information contained in the record. MHSCC and its officers, employees and agents will:
  - a. Permit consumers access to their medical records except when access would be detrimental to the consumer under the so-called “therapeutic exception” to consumer access. In such cases, MHSCC and its officers, employees and agents will provide an authorized representative access to the consumer's records in accordance with law, professional ethics and accreditation requirements. (Procedure VII- Client Access)
  - b. Provide consumer an opportunity to request correction of inaccurate data in their records in accordance with the law and professional standards. (Procedure VII)
9. Assure the safe and secure transportation of records between the different service locations, including contracted service locations. (Procedure VIII- Transportation of Records)

**PROCEDURE I: AUTHENTICATION OF ENTRIES IN THE CLIENT RECORD**

1. All entries made in the client record shall be dated, signed, and authenticated by recording either the professional degree or license/certification. If a staff member does not have a degree or license/certification, he/she is to use his/her working title when signing off on client documentation. Case Managers must sign as “case manager”.  
  
Example:  
Staff with professional degree- Jane Doe, M.A.  
Staff without professional degree- John Doe, Group Home Manager
2. **The use of rubber stamp signatures is not permitted when documenting in the client record.**

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HISTORY NOTE:

MHSCC P&P #4.003f . APSM 45-2, Service Records Manual. AMT approved 02-17-82 and effective 02/17/82. Amended 03/02/95, 10/04/98 and 09/07/00.

**PROCEDURE II: ALTERATIONS TO CLIENT RECORDS**

- A. Making alterations to non-electronic medical records:
  - 1. Alterations must be made by the individual who recorded the entry.
  - 2. Draw a single, thin line through the error or inaccurate entry, making certain that the original entry is still legible.
  - 3. The corrected entry shall be legibly recorded above or near the original entry.
  - 4. Record the date of alteration and initials of recorder. An explanation as to the type of error should be included whenever the reason for the alteration is unclear (e.g., "wrong client record", "transcription error").
  - 5. Insert the word(s) in the appropriate place above the record entry, whenever a word or few words have to be added to the record entry.
  - 6. Add the information after the last entry in the record when information is more than a few words. Never "squeeze" additional information into the area where the entry should have been recorded.
- B. Making alterations to electronic medical records:
  - 1. Any staff aware of errors made in electronically maintained medical records shall immediately notify the Medical Records Manager (or his/her designee) of the errors prior to his/her authenticating the document.
  - 2. The designated medical records clerk will make all appropriate and allowable corrections.
  - 3. The clinician is responsible for reviewing and signing corrected documents.
  - 4. The corrected electronic documentation is placed in the medical record.
  - 5. If a situation occurs where a document needs to be modified after it has been authenticated and placed in the medical record, the clinician should create a new ISN in CMHC and identify it as an addendum to the particular document. This ISN is then printed, signed and placed in the medical record with the original entry.
- C. Corrections or alterations to medical records should NOT include the use of correction fluid.

HISTORY NOTE:

MHSCC P&P #4.013. Approved by AMT on 10/14/98 and effective 10/14/98. APSM 45-2, Service Record Manual, Chapter 5, Section 10, Alterations in the Client Record.

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**PROCEDURE III: SECURITY/ACCESSIBILITY OF CLIENT RECORDS**

1. All client information is kept in locked files or in a file cabinet/bin which is maintained in a room which can be locked and is devoted to the storage of medial records/client information.
2. Only clerical staff are designated to pull client records.
3. When a record is removed from the file, an out guide must be inserted in its place. The out guide must indicate who the record is signed out to, name of client and date record was removed from the file.
4. The individual receiving the record assumes responsibility for the security of the record until it is returned to the Medical Records Department.
5. Records must be returned to the Medical Records Department by 5:00 p.m., or at the end of the regular workday and locked in the file cabinets/room. The Medical Records Department will be locked at the end of the day.
6. Original client records may be removed from the Area Program with prior approval from the Medical Records Manager only under the following conditions:
  - a. In accordance with a subpoena to produce documents/objects or other specialized order of the court.
  - b. Whenever client records are needed for audit purposes, records may be transported to contract facilities.
  - c. In life-threatening situations, client records may be securely transported to local health care provider, provided the record remains in the custody of the delegated employee.
  - d. When transporting a client records to another location, it must be placed in a locked, concealed compartment and remain in the care of the individual transporting it.
7. Duplicate client records may be maintained at satellite units when primary intervention occurs there. All satellite offices shall follow the same requirements as the Area Program in providing a secure place for the storage of client records.
8. The Area Program assures that all client information entered in the computerized system is confidentially maintained. Our system has a built in safety feature that is controlled by individual passwords and only the appropriate operators have knowledge of the passwords.
9. Instructions on access to medical records during hours the clinic is closed (evenings, weekends, and holidays) shall be maintained in the agency Emergency Services Kit.

**HISTORY NOTE:** MHSCC P&P #4.003b. NC Confidentiality Regulations, APSM 45-1, .0121, .0123; Security of Client Information, APSM 30-1, 14V, Section .0201 (5)c and d. APSM 45-2, Chapter 14, Section 3a. Approved by AMT on 02/17/82. Amended 06/30/86, 03/30/89, 03/02/95, 10/14/98 and 09/07/00.

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**PROCEDURE IV: ASSURANCE OF CONFIDENTIALITY**

1. All new personnel, students, and volunteers are seen by the Staff Trainer for orientation to North Carolina Division of Mental Health, Developmental Disabilities, and Substance Abuse Services confidentiality regulations and the agency's policies and procedures regarding these regulations.
2. Such individuals shall indicate an understanding of the rules governing client confidentiality by signing a statement of compliance and understanding (Assurance of Confidentiality Statement). This signed statement is filed in staff personnel files.
3. The Assurance of Confidentiality Statement is signed annually with the employee annual performance evaluation to ensure all staff are reminded of the importance of protecting client confidentiality and to educate staff on any changes in the confidentiality regulations.

**HISTORY NOTE:** MHSCC P&P #4.003a. Confidentiality Regulation APSM 45-1 .0124, 01/01/94. Assurance of Confidentiality. Approved by AMT 02/17/82 and effective 02/17/82. Amended 04/01/87, 03/30/89, 03/02/95, and 09/07/00.

**PROCEDURE V: RELEASE OF INFORMATION WITH CONSENT OF CLIENT**

- A. Persons designated to release client information:  
The Medical Record Manager is responsible for assuring that any information released from such facility in response to a request for information is adequate, in acceptable format, and is released only in accordance with these Policies and Procedures.
- B. Clients Rights to Privacy:  
The Reimbursement Officer is responsible for informing the client of his/her right to privacy. A Consent for Evaluation and/or Treatment is also signed by the client at this time. (See Attachment I.)
- C. Releasing Client Information with Client's Consent:
  1. Client information may be released upon obtaining a completed Consent for Release of Client Information form. Below is a list of persons authorized to sign consent to release information:
    - a. The adult client
    - b. The parent or legal guardian if the client is a minor.
    - c. The legal guardian, if client has been adjudicated incompetent.
    - d. An agent with a valid power of attorney

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- e. Minor clients under the following conditions:
  - . when seeking services for venereal disease and other diseases reportable, etc., pregnancy, substance abuse, or emotional disturbance.
  - . when married or divorced
  - . when emancipated by a decree issued by a court of competent jurisdiction
  - . when a member of the armed forces
  - . when consenting for release of information to his/her own attorney

- 2. Personal representative of a deceased client if the estate is being settled or next of kin of a deceased client if the estate is not being settled.

D. Content for Release

- 1. The client shall never be asked to sign a blank release for information form. The form shall contain the following information:
  - a. Client's name
  - b. Name of facility releasing the information
  - c. Name of individual/agency to whom information is being released
  - d. List of information to be released
  - e. Purpose of the release
  - f. Length of time consent is valid
  - g. A statement that the consent is subject to revocation at any time except to the extent that action has been taken in reliance on the consent
  - h. Signature of the client or legal guardian
  - i. Date consent is signed
- 2. Unless revoked sooner by the client or guardian, a consent for release of information shall be valid for a period not to exceed one year except under the following conditions:
  - a. A consent to continue established financial benefits shall be considered valid until cessation of benefits; or
  - b. A consent for release of information to the Division of Motor Vehicles, the Court and the Department of Corrections for information needed in order to reinstate a client's driving privilege shall be considered valid until reinstatement of the client's driving privilege.
- 3. A consent for release of information received from an individual/agency does not have to be on the form utilized by the area program, however it does need to be determined that the content of the consent form conforms to the requirements set forth by the Confidentiality rules.
- 4. A legible photocopy of a consent for release of information may be considered to be as valid as the original.

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E. Doctrine of Informed Consent Explained to the Client:

In order to protect the clients we serve and those who may be vulnerable as a result of mental disability or functional illiteracy, clients must be verbally informed of the following before signing a Consent to Release Information:

1. Contents of the record to be released.
2. That there is a definite need for the information.
3. That the client can give or withhold the consent and that the consent should be voluntary.
4. That the provision of services is not contingent upon such consent.
5. That there are statutes and regulations protecting the confidentiality of the information being released.

F. Verification of Consent in Cases of Doubt:

If a staff member questions the validity of a signed consent to release information, due to an improper signature, an old date, a condition added to the language of the form, or any other reason, the client should be contacted by phone or letter for the purpose of confirming that the consent is valid before any information is released.

G. Releasing of Client Information:

Once a properly signed Consent is obtained, the requested information shall be released as described below:

1. All letters, summaries of treatment, and other information sent out in response to requests for information should be typed and signed by the originator.
2. All copies released from the medical record shall be stamped with the required state and federal "sensitive information" stamps which prohibit the redisclosure of information without client consent.
3. It shall be documented on the Accounting of Release/disclosure form which documents were released or disclosed, the date, to whom, the method and purpose for which the information was released/disclosed. This form is signed by whomever is releasing the information and filed in the client record.
4. The signed consent to release information form is filed in the client record.
5. Disclosures will be monitored at the monthly Documentation Team meetings to ensure proper release.

H. Requesting Client Information from other Facilities:

When a clinician is made aware that a client has received services from another health care facility, the client will be asked to sign a consent form in order to obtain confidential records from that facility. Once the proper consent is obtained, it will be mailed to the other facility.

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- I. The Releasing of Information Received from other Facilities:  
Whenever confidential information is received from other state, local, or private facilities, such information shall be treated as any other confidential information generated by the Area Program. This information shall be maintained and released/disclosed according to the agency's policy and procedures regarding the release of client information.
- J. The Cost for the Reproduction of Client Records:  
The agency shall charge a fee for the reproduction of client records. The fee shall be five (\$5.00) dollars for up to three pages and twenty-five (\$.25) cents for each additional page. The agency shall waive charges for the reproduction of client information in the following types of situations:
1. Information requested by another treatment professional.
  2. When indigent clients request pertinent portions of their records be released for the purpose of establishing SSI, Medicaid, or other legitimate aide.
  3. Third-party payors when the facility will derive direct financial benefits.
  4. Other situations determined by the Area Director to be for good cause.
- K. Releasing Confidential Records to Attorneys:  
When an attorney requests copies of the medical record, a letter is sent to the attorney requesting that he issue a subpoena duces tecum. After receiving the subpoena, two copies of the requested client records are made. One copy is sent to the attorney and the other to the Clerk of Court to the attention of the judge handling the case.
- L. Releasing Confidential Information Relative to a Client with HIV Infections, AIDS, or AIDS - related Conditions:
1. All information and records that would identify a person who has the AIDS virus infection or who has or may have a disease/condition required to be reported to proper authorities shall be strictly confidential. Such information shall not be released or made public except under the following circumstances:
    - a. Release is made for statistical purposes in a way that no person can be identified.
    - b. Release is made with the written consent of the client, or guardian.
    - c. Release is made to health care personnel providing medical care to the patient.
    - d. Release is necessary to protect the public
    - e. Release is made pursuant to subpoena or court order
    - f. Release for the purpose of research
  2. When the client record reflects that a client has AIDS or one of the other communicable diseases, it should be determined by the client prior to releasing those records, whether that information should be released.
- M. Release to Human Rights Committee Member.  
See Clients Rights Policy - 5.001-R.

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HISTORY NOTE

MHSCC P&P #4.003d. APSM 45-1 - Confidentiality Regulations, dated 01/01/94; .0207, .0208, .0209, .0210, .0211, .0212, .0213, .0214, .0215, .0126, .0322, .0325, and 0324. Effective 02/17/82. QMT approved 10/06/00. Amended 04/01/87, 03/30/89, 03/02/95, 10/14/98, 10/06/00, and 11/10/00.

PROCEDURE VI: **RELEASE OF INFORMATION WITHOUT CONSENT OF CLIENT**

1. Situations in which client information **MUST** be disclosed without client consent:

- a. Upon request from a treatment facility as defined below, information **MUST** be disclosed to the extent necessary for the requesting facility to meet the service needs of the client. A treatment facility is defined as any hospital or institution operated by the State of North Carolina for the purpose of treating Mental Illness, Mental Retardation, or Substance Abuse and any area mental health program operated in conjunction with the State of North Carolina.
- b. Upon request, information **MUST** be furnished to special counsel representing respondents in commitment hearings and rehearing, to the Court, and to counsel representing the interest of the State in commitment hearings and rehearing.

NOTE: In both of the above instances, disclosure of information via telephone must include a callback to verify the validity of the request and the identity of the requesting party.

2. Situations where client information **MAY** be disclosed without consent of client:

In the following instances, client information may be disclosed as described in Item 5 below without obtaining a signed Consent form

PROVIDED the clinician responsible for the client's care determines that the release of such information is necessary to meet the service needs of the client or to comply with state or federal statutes or regulations. Such disclosure of information must be documented in a progress note as described in item 3 below.

- a. Information may be disclosed to a facility or individual that is providing emergency medical services to a client but only to the extent necessary to meet the emergency. NOTE: Disclosure of information via telephone must include a callback to verify the validity of the request and the identity of the requesting party.
- b. Information may be disclosed if there is imminent danger of the client's inflicting serious bodily injury upon another person.
- c. Information may be disclosed for the purposes of clinical, financial, or administrative audit, PROVIDED:
  - (1) That there is justified, documented need for the disclosure of such information.
  - (2) That each person performing such an audit signs an Assurance of Confidentiality.

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- d. The fact of the client's admission can be disclosed to the client's next of kin, PROVIDED that the clinician responsible for the client's care determines that such disclosure is in the best interest of the client. The Accounting of Release form must subsequently be completed by the clinician.
  - e. Information may be disclosed in response to a court order or to a subpoena duces tecum.
  - f. Information may be disclosed under other special circumstances. Questions relating to whether or not information can be disclosed in special circumstances would be directed to the Clinical Director or the Medical Records Manager.
3. Documentation of disclosure in the client record required. Whenever client information is disclosed without client consent, the fact of such disclosure MUST be documented on the Accounting of Release/Disclosure of Client Information Form or in the progress note in the record and must include the following information:
  - a. Name of recipient of information.
  - b. Extent of information disclosed.
  - c. Specific reasons for disclosure.
  - d. Date of the disclosure
  - e. Signature of the person disclosing the information.

NOTE: Repeated disclosures by MHSCC to the same agency about the same client may be documented in a progress note or Accounting of Disclosure form.

4. Release of Information: Once a determination of the necessity of releasing client information without client consent is made and documented in the record, client information may be disclosed as described in 5. below.

5. Procedure for sending out information:

1. All letters, summaries of treatment, and other information sent out in response to requests for information should be typed
  2. Information being disclosed must be stamped with the following statements:

**SENSITIVE INFORMATION**  
**When requested by client, must be shown and/or**  
**interpreted by competent clinician. Redisclosure**  
**without client consent, is prohibited by law.**

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If the information being disclosed is of an alcohol or drug nature, the information must be stamped with the following statement:

**This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR Part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse client.**

3. The information being disclosed should be sent out under a cover letter and typed on the local facility's stationary.
4. All requests for specific written information shall be submitted to the Medical Records Manager or her designee.
5. The Medical Records Manager shall:
  - a. Maintain responsibility for all written client information disclosed for any purpose.
  - b. Consult with the clinician responsible for the case or the Clinical Director when questions of propriety of the release occur.
6. Any letter explaining or interpreting client information that accompanies a response to a specific request for information should be signed by the clinician responsible for the case or the Clinical Director.

HISTORY NOTE: MHSCC P&P #4.003e. APSM 45-1 effective 01/01/94; .0214 and .0323. Approved by the Area Management Team on 02/17/82 and effective 02/17/82. Amended effective 03/30/89, 03/02/95, and 09/07/00.

**PROCEDURE VII: CLIENT ACCESS**

- A. Viewing client information is the privilege of the client, or if the client is a minor, it is the privilege of the legal guardian. The client/legal guardian is permitted to review his/her record upon written request, PROVIDED the Clinical Director agrees that such review is advisable. Carefully follow this procedure, using the Client Access to Record Form whenever a client asks to review his/her record:
  1. The "Client Request to Review Record" portion of the form is completed and signed by the client and witnessed by an employee of MHSCC.

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2. The clinician responsible for the client's care indicates his/her recommendation regarding such review by checking the appropriate box in the "Recommendation of Qualified Professional" portion of the form and signing and dating the entry.  
**NOTE:** When the clinician responsible for the client's care is also the Clinical Director, the "Recommendation of Qualified Professional" portions of the form do not have to be completed.
  3. The Clinical Director reviews the client's request and the clinician's recommendation, determines whether or not any or all information should be released, and documents such decision in the "Determination by Clinical Director" portion of the form.
  4. If the Clinical Director's decision is that the client should be permitted to review the record:
    - a. The client is permitted to review the record in the presence of the clinician or the Clinical Director.
    - b. The clinician in whose presence the review was performed then completes and signs the "Documentation of Review" portion of the form.
  5. If the Clinical Director's decision is that the client should NOT be permitted to review the record, based on the potential harm that the information could cause to the client, the client is so notified. The client/legally responsible person then may request that the information to be sent to a physician or psychologist of the client's choice and, in this event, the information shall be so that provided.
- B. If a client who is permitted to review the record contests the accuracy, completeness, or relevancy of information in the record, he/she may wish to insert a correction of the contested portion of the record and should be permitted to either insert a correction/or add a statement to the record, based upon the decision of the Clinical Director as follows:
1. If the clinician agrees with the client that such correction is justified and if the correction is approved by the Clinical Director:
    - a. The correction may be inserted in the record, PROVIDED that the contested portion of the record is NOT deleted.
    - b. The "Contested Portion of the Record" section of the Client Access to Record form is then completed by the client and the clinician.
    - c. The correction inserted in the record as described above must be disclosed to any future recipient of the disputed information.
  2. If the clinician agrees with the client that such correction is justified but the correction is NOT approved by the Clinical Director:
    - a. The client may add a statement to the record by writing such statement in the "Contested Portion of Record" section of the Client Access to Record form and signing and dating his/her statement.

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- b. The clinician then completes the lower portion of the form.
    - c. The statement of the client which is thus added to the record must be disclosed to any future recipient of the disputed information.
  - 3. If the clinician does NOT concur with the client that the correction is justified, the final decision as to whether the correction may be inserted in the record is made by the Clinical Director.
    - a. If the final decision is that the correction is justified, the correction may be inserted in the record as described in B.I above.
    - b. If the final decision is that the correction is NOT justified, the client may add a statement to the record as described in B.I above.
- C. Upon receipt of a completed Client Access to Record form, the Medical Records Manager:
  - 1. Files the form in the client's record.
  - 2. If the "Contested Portion of the Record" section of the form is completed, writes the word "CONTESTED" on the front of the client record folder in large red letters.

HISTORY NOTE: MHSCC P&P #4.003c. Confidentiality Regulation APSM 45-1 .0121 Client Access. Approved by the Area Management Team on February 17, 1982 and effective February 17, 1982. Amended effective 06/30/86, 03/30/89, 03/02/95, and 09/07/00.

**PROCEDURE VIII: TRANSPORTATION OF RECORDS**

- 1. Only authorized employees will be permitted to transport service records between area facilities.
- 2. When transporting original service records, care should be taken in making sure the records are placed in a black transportation bag.
- 3. The records should be kept in a locked compartment (trunk) while transporting the records between area facilities.
- 4. The records should be logged out or checked out via outguide before transportation of service records is permitted.

HISTORY NOTE: MHSCC P&P #4.012. APSM 30-1, 14V, Section .0201(5)(b), APSM 45-2, Chapter 14, Approved by AMT on 10-14-98. Effective 10-14-98.